

Bureau Talk

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>



STAFF CHANGES in the Bureau

On April 1, 2012, the bureau said goodbye to Becky Cooke, a health facilities nursing consultant from southeast Missouri. Although Becky will no longer work for the bureau full time, she joins two of our previous surveyors, Gerry Ann Wagner, R.N., and Lois Kollmeyer, R.N., as an H & I (Hourly and Intermittent) employee. The three will assist our other full-time surveyors in completing CMS-tier survey work. We are excited to have them back as part of the bureau team!

In August the bureau will welcome new survey team member Pamela Yeager, R.N., B.S.N., who resides in the Farmington area. Although her primary area will be southeast Missouri, Pam will assist with surveys statewide when needed. Pam is currently a long-term care surveyor. In addition to her surveyor experience, she has been a hospital and long-term care nurse. Pam also holds a nursing home administrator license.

Another new, yet familiar, face has returned to the section. In May, Dean Linneman returned to the Section for Health Standards and Licensure as section administrator. Bill Koebel now serves as the deputy section administrator.

Please join the bureau in welcoming Pam and Dean!

New Aide Competency Evaluation



The previous *Bureau Talk* indicated the new Missouri Home Health Aide/Hospice Aide Competency Evaluation went into effect on 03/01/12.

Providers have been asking the bureau, *Does an aide have to be checked off on the entire skills checklist before he or she can see a patient independently?*

A home health/hospice aide has to be checked off satisfactorily on all but one of the “Basic Skills Test” tasks before seeing a patient independently. For the “shampoo” task, an aide only needs to be tested on one method and master that method.

Before an aide is deemed qualified to care for a patient independently, the test also states that the aide must be observed performing **ALL** the listed tasks on a **patient**. The

basic skills test tasks are just that— basic and minimal.

If you have not yet obtained the new competency evaluation, please contact the bureau at 573/751-6336 , or email Randi Sherrell at Randi.Sherrell@health.mo.gov.



Established in 1994, the Missouri Medicaid Fraud Control Unit (MFCU) investigates abuse and neglect of persons receiving health care through Medicaid. The unit also investigates abuse and neglect of persons in board and care facilities, regardless of their payment source, potential fraud by providers, and patient trust-fund theft in Medicaid-licensed facilities. The MFCU currently consists of four attorneys, three auditors, three assistants, nine investigators and one computer technician.

The MFCU receives complaints from the general public, either by phone or the website www.ago.mo.gov, other providers, employees of providers, Medicaid recipients and providers making self-reports. The unit also receives complaints from governmental agencies such as Missouri Medicaid Audit and Compliance, the Department of Health and Senior Services and the Office of Inspector General Health and Human Services. The complaints prompt investigations. MFCU also has a hotline, 1-800-286-3932.

If you have any questions regarding the Missouri Medicaid Fraud Control Unit, contact Mary Johnson, auditor, Missouri Attorney General's Office, at 573-751-1244, or send an email to mary.johnson@ago.mo.gov.

Home Health Issues

Home Health Statement of Deficiencies

Surveyed agencies may find that their statement of deficiencies reports look different. At a recent CMS Federal Home Health Training, surveyors learned that when writing a statement of deficiencies for home health surveys, they may review twelve clinical records and find problems in an area in all twelve records; however, all twelve records may not be cited in the statement of deficiencies. Surveyors have been instructed to pick approximately 25 percent of the problematic records and write their findings only on those records. The universe will still be the total number of records reviewed. However, if condition level deficiencies are cited, findings in all records will be written.



High-Risk Drug Education

The bureau is aware that process measures, now captured in the OASIS-C data set, are not federally mandated; however, prudent nursing judgment and quality care are mandated.

Surveyors encounter problems in two areas:

- 1) Agencies are not identifying the high-risk drugs a patient takes.
- 2) Agencies are not documenting their efforts to educate patients and caregivers about high-risk drugs.

Agencies should have policies that identify high-risk drugs. They should document, in the clinical record, their efforts to inform patients and caregivers about high-risk drugs, and how well patients and caregivers comprehend and retain the information. Agencies should also document any barriers to learning.

The bureau was asked, *Can an OT/PT teach high-risk drug education?* Per the commission liaison for the State Board of Registration for Healing Arts, “It was the decision of the Advisory Commission to refer to Section 334.500(4), RSMo, specifically the portion that states:

- “Practice of physical therapy...does not include the prescribing of any drug or medicine or the administration or dispensing of any drug or medicine other than a topical agent administration or dispensed upon the direction of a physician.”
- The Commission also advised that the management of patient medication should be completed by the nurse or physician involved in the patient’s care; however, the statute does not prevent a physical therapist from listing medication in a patient’s chart.

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Pulse Oximetry

Accrediting organizations may require a physician order for pulse oximetry, but surveyors have never cited an agency that failed to have such an order. That's about to change. The bureau has received direction from CMS Central Office. A physician order for pulse oximetry that includes parameters is a requirement, and surveyors can cite an agency if it does not have such an order. Because this is a new practice, the bureau will allow agencies a learning curve. However, by the end of the calendar year, all Medicare or state-licensed home health agencies will be required to follow this CMS requirement or be cited with a deficiency.

Proposed Rule

Proposed rule CMS-1358-P was published in the *Federal Register* on 7/13/2012. The proposed rule updates the Home Health Prospective Payment System rates, including the national standardized 60-day episode rates, the national per-visit rates, the low-utilization payment amount, and outlier payments under the Medicare prospective payment system for home health agencies effective Jan.1, 2013. This rule also proposes requirements for the Hospice Quality Data Reporting Program. The proposed rule also establishes requirements for unannounced, standard and extended surveys of home health agencies (HHAs) and provides a number of alternative (or intermediate) sanctions that can be imposed if HHAs are not in compliance with federal requirements. The proposed rule sets forth alternative sanctions instead of or in addition to termination of an HHA's participation in Medicare. Those sanctions can remain in effect up to a maximum of six months— until the HHA achieves compliance with the HHA Conditions of Participation or the HHA's provider agreement is terminated.

Comments about the proposed rule must be received by 5 p.m. Sept. 4, 2012. The process for submitting comments can be found in the proposed rule at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1358-P-New.html>.

Referrals by Hospitalists

An agency recently pointed out that more and more referrals are coming from hospitalists—the physicians who care for hospitalized patients—especially in the larger cities. However, when that home health agency (HHA) contacted a patient's primary care physician, the one who signs the patient's care plan after discharge, the primary care physician refused to order home health for the patient. So the HHA was in a quandary. It had to evaluate the patient within 48 hours of the hospitalist's referral, yet it could not provide home health services to the patient after discharge because the patient's primary care physician did not order them. The agency asked if it could make a policy that a "referral" must be received from the physician who signs the patient's care plan. Other agencies may encounter this same challenge, so the bureau received the following answer from CMS Central Office. (continued on Page 5)

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“The conditions of participation states the initial assessment must be conducted within 48 hours of the referral. The regulations are silent on the definition of referral. OASIS defines it as the date authorization is received to visit the patient. In the scenario described above, the authorization is received from the hospitalist; therefore, the HHA has to see the patient within those 48 hours. That includes getting follow-up authorization/confirmation of a follow-up physician. It would benefit the HHA in this situation to follow-up with the hospital administration. Good discharge planning should include assuring that if a referral is made (identifying a need) that it is doable for the HHA also.”

ICD – 10 Coding

The comment period for CMS-0040-P, the proposed rule that delays ICD-10 implementation to Oct. 1, 2014, has ended. However, there has been no official announcement as to whether there will be a delay.

In the meantime, CMS recommends that agencies proceed as if ICD-10 were going to be implemented on Oct. 1, 2013.

Teresa Northcutt, R.N., B.S.N., COS-C, HCS-D, a home health and coding consultant, recently did a very informative presentation for the Home Health Advisory Council on the upcoming ICD-10 coding requirements. With Teresa's permission, Attachment 1 includes her presentation handouts.

OASIS

The CMS 2nd Quarter Q&A Update has been published. These Q&As can be obtained by visiting www.qtso.com, and clicking on OASIS.

The Q&As relate to how to select accurate OASIS responses for:

- completing questions in the neuro/emotional domain related to cognitive functioning, confusion and psychiatric nursing;
- reporting fall risk assessment for patients who are unable to complete standardized tests;
- completing plan of care and intervention synopsis items; and,
- questions specifying new surgical wound clarifications.

CMS has also posted two new training modules on its website, <http://surveyortraining.cms.hhs.gov/index.aspx>. The modules are OASIS-C Online Training: Neuro/Emotional/Behavioral Domain and OASIS-C Online Training: Care Planning and Intervention. A third module, OASIS-C Online Training: Medications, has been posted for quite some time. Facilities can use all three training modules agencies in their facilities.

Hospice-Related Issues

Standing Orders

The bureau received the following question. *Do surveyors expect all standing orders to be on the coordinated care plan in the nursing home, even if those orders are not being used by the patient?* The answer is no. Surveyors expect the nursing home and the hospice agency to collaborate on the information contained in the coordinated care plan.

Proposed Rule

The CMS proposed rule (CMS-1358-P), published in the *Federal Register* on 7/13/2012, proposes requirements for the Hospice Quality Data Reporting Program.

To be assured consideration, comments must be received no later than 5 p.m. on Sept. 4, 2012.

The entire proposed rule can be accessed at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1358-P-New.html>



Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.

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